In the Supreme Court

Appeal from the Eaton Circuit Court
Hon. Calvin Osterhaven

ADVOCACY ORGANIZATION FOR PATIENTS & PROVIDERS,
a non-profit Michigan corporation, et al.,

Plaintiffs-Appellants,

-vs- Docket No. 124639

AUTO CLUB INSURANCE ASSOCIATION, et al.

Defendants-Appellees.

PLAINTIFFS-APPELLANTS' BRIEF ON APPEAL

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STATEMENT OF QUESTIONS PRESENTED

I.

DID THE COURT OF APPEALS ERR IN HOLDING THAT DEFENDANTS' ACTIONS ARE PERMITTED UNDER MCL 500.3157?

Plaintiffs AOPP et al. answer "YES."

Defendants ACIA et al. would answer "NO."

The Court of Appeals would answer "NO."

II.

DID PLAINTIFFS STATE A CLAIM FOR TORTIOUS INTERFERENCE WITH CONTRACTUAL AND BUSINESS RELATIONSHIPS"

Plaintiffs AOPP et al. answer "YES."

Defendants ACIA et al. would answer "NO."

The trial court answered "NO."

The Court of Appeals answered "NO."

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INTRODUCTION AND SUMMARY OF ARGUMENT

The controversy in this matter can be summarized fairly simply: do Michigan no-fault insurers have the right to pay medical providers for treatment of victims of motor vehicle accidents based on what the insurers and medical review companies decide should be paid, when the both the insurers and the review companies apply the wrong standard for making that determination?

The no-fault act requires no-fault insurers to pay the "reasonable expenses" of medical care required by the victims of motor vehicle accidents. Providers of medical care are permitted to charge a "reasonable amount" for treating patients injured in motor vehicle accidents. The only limitation on providers' fees is that they cannot exceed the charge for a comparable service to an uninsured patient. MCL 500.3157.

Rather than comparing providers' fees for services to no-fault insureds with their fees to other patients, however, defendants and the review companies they employ compare providers' fees to those of other providers. They then pay only what they consider the "reasonable and customary" fee. Some employ a particular method they call the "80th percentile" system, which terms a charge "reasonable" only if it is at or below what 80% of other providers charge for the same service.

Plaintiffs, health care providers and two injured parties, sued defendant no-fault insurers and review companies for injunctive, declaratory and other relief. The Eaton Circuit Court dismissed their claim. The Court of Appeals affirmed in a published opinion. 257 Mich App 365.

The Court of Appeals erred in holding that defendants' actions are permitted under MCL 500.3157. It has been established that no-fault insurers do not have the right to decide on their own how much they will pay service providers for treating motor vehicle accident injuries. The

"80th percentile" system is unacceptable, because it arbitrarily identifies 20% of providers' charges as "unreasonable," regardless of how high or low they are. Although several no-fault jurisdictions have legislatively-created cost containment provisions, those statutory arrangements include built-in protections of various kinds for providers and are not comparable to the private, insurer-imposed, methods employed by defendants.

Defendants' review system treats providers as if they had agreed to a bargained-for exchange of lower rates in return for larger volume. Plaintiffs, however, do not have such contractual relationships with defendants and should not be forced to accept the effect of contracts they did not enter into. The Court of Appeals' decision requires that every fee dispute be litigated individually, an approach that will needlessly increase the cost of health care and no-fault insurance.

This Court has held that no-fault insurers are effectively agents of the state, because purchasing auto insurance is mandatory. When the Legislature delegates its rule-making capacity, however, it must provide standards for those exercising the delegated authority or the action is an unconstitutional delegation of legislative power. In the case of no-fault insurance provider payments, it would be unconstitutional for the Legislature to delegate its powers to no-fault insurers and leave them complete discretion to set reimbursement rates. The only legislated standard, MCL 500.3157, therefore, must be applied.

When defendants did not pay the providers in full, some of them would attempt to collect the remainder of their charges from their patients. Many defendants informed the patients that they had no liability for these charges. In addition, defendants sent false and threatening letters directly to providers, regarding their bills to their patients. Plaintiffs contend that these actions constitute tortious interference with business and contractual relationships. Plaintiffs also assert

that defendants insurance companies and defendants review companies have conspired to interfere with the providers' relationships with their patients.

The lower courts erred in dismissing plaintiffs' complaint for tortious interference with contractual and business relationships. Defendants' actions in sending letters to providers containing false statements were per se wrongful. Defendants interfered with the contractual relationship between plaintiff providers and their patients, defendants' insureds. Plaintiffs' tortious interference claims should not have been dismissed.

This Court should reverse the Court of Appeals.

STATEMENT OF FACTS

In its most recent decision on the no-fault insurance system, this Court referred to the "great compromise" of the no-fault act. *Kreiner v Fischer*, ___ Mich ___ (Docket No. 124120, rel'd 7/23/04), slip op, p 35. While *Kreiner* focused on the trade-off between assurance of economic recovery and reduction in noneconomic damages, the same statutory system also provides for another type of compromise.

Under a no-fault system, owners of motor vehicles[1] are required to purchase insurance in order to operate their vehicles legally in Michigan. MCL 500.3101(1); MCL 500.3102(2). In return, however, they are guaranteed payment of medical expenses arising out of their use of those vehicles. MCL 500.3105(1).

In order to insure that insureds' medical expenses will be covered, the statute requires that providers of no-fault insurance pay them:

> [P]ersonal protection insurance benefits are payable for the following:
>
> *Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.* . . . [MCL 500.3107(a). Emphasis supplied.]

As the Court of Appeals said in a recent decision, "Michigan's no-fault insurance system has at its core the premise--and the promise, of wide-ranging medical benefits from the available spectrum of providers, in exchange for which the driving public accepts the statutorily-prescribed, limited redress for personal injuries suffered." *Michigan Chiropractic Council v Comm'r of Financial & Ins Service*, ___ Mich App ___ (Docket No. 241870, rel'd 6/1/04), slip op, p 10.

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[1] Portions of the act apply to other than "owners" and some non-"owners" are also entitled to benefits, but those aspects of the statute are not relevant here.

To protect the interests of those who provide treatment to no-fault insureds, the statute also guarantees them the right to reasonable compensation for their services:

> *A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person* for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, *may charge a reasonable amount for the products, services and accommodations rendered.* . . . [MCL 500.3157. Emphasis supplied.]

The only limitation on such charges is that they "shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance." MCL 500.3157. Finally, the statute requires that insurers make prompt payments to providers "as loss accrues." MCL 500.3142.

The no-fault act became effective in March of 1973. For the next nineteen years, Michigan no-fault insurers routinely paid claims for their insureds injured in motor vehicle accidents. Although insurers sometimes contested that a given service was not "reasonably necessary," MCL 500.3107(1)(a), in a particular case, they operated within the parameters of MCL 500.3157 and paid medical providers "a reasonable amount for the products, services and accommodations rendered."

Insurers' attempts to change the no-fault scheme[2]

In *Nasser v Auto Club Ins Ass'n*, 435 Mich 33; 457 NW2d 637 (1990), this Court held

[2] Both defendants and the Court of Appeals misunderstood plaintiffs' discussion of the background of the present litigation. The Court of Appeals dismissed it as "legislative history," irrelevant to interpretation of the allegedly unambiguous statute. 257 Mich App 381. What happens *after* a statute is enacted is not, of course, "legislative history." The Court of Appeals itself considered some of the same developments in *Munson Medical Center v Auto Club Ins Ass'n*, *infra*, noting that "Despite its failure to obtain an amendment of the no-fault law, ACIA nonetheless unilaterally implemented the result it wanted." 218 Mich App 390 (Appendix, p 69a). Finally, plaintiffs have never argued that the statutes are ambiguous, requiring legislative history to interpret. On the contrary, plaintiffs' arguments have been based in the plain language of §3157 of the no-fault act.

that "each . . . expense . . . must be both reasonable and necessary." *Id.* at 50. Insurers, then, had the right to challenge the "reasonableness" of providers' charges in the judicial arena.

As the cost of medical care increased in the 1980's, however, insurers, including defendants, began to seek ways to cut expenses without the inconvenience of contesting payments on a case-by-case basis. The Automobile Association of Michigan ("AAA") introduced a bill, SB 691, in the 1992 session of the Legislature. (Appendix, pp 75a-78a.) House Legislative Analysis of HB 4156 (7-29-93), p 3 (Appendix, p 103a.). SB 691 was passed by both houses.[3] The act would have made a number of changes to the no-fault scheme (see text of SB 691, Appendix, pp 75a-78a), including the addition of a §3109b. (Appendix, pp 75a-77a.) Proposed §3109b would have required all no-fault insurers to establish a "utilization and review" system for no-fault medical benefits. (Appendix, pp 77a-78a.)

Governor Engler vetoed SB 691 in a sharply-worded message dated April 3, 1992. (Appendix, pp 79a-83a.) He described the bill as "an election year gimmick rushed through the legislature on a tide of misinformed lust for short term political gain." (Veto message, p 1; Appendix, p 79a.) He did, however, urge the Legislature to "try again." (Veto message, p 3; Appendix, p 82a.) An override vote failed in the Senate. 1992 Journal of the Senate 1102-1103.

Rather than "trying again" in the Legislature, however, the insurance lobby went to the public with an initiative petition "for amending certain provisions of the Michigan Insurance Laws, specifically . . . sections 3101, 3104, 3107, 3109a, 3111, 3115, and 3135 of Chapter 31, commonly known as the No-Fault Insurance Act . . ." (Appendix, pp 87a-92a) Insurers, including AAA[4], urged their policy holders to support the petition. (Complaint Exhibit 6[5].)

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[3] The Senate vote was 36 to 0. 1992 Journal of the Senate 272. In the House, it was 63 to 35. 1992 Journal of the House 643-644.

[4] AAA writes no-fault insurance through defendant Auto Club Insurance Association.

One of the proposed sections was the following:

> 3107(4). Allowable expenses shall not exceed the maximum amount a health care facility or provider is entitled to be paid or reimbursed for treatment, service, accommodation, and medication pursuant to the fee schedules contained in R418.101 to R418.2324 of the Michigan Administrative Code. The Commissioner [of Insurance] shall, as soon as practical, develop rules to establish schedules of maximum fees or charges for use under this subsection which shall not exceed the maximum fees or charges established in R418.101 to R418.2324 and may adjust his or her own schedules from time to time as may be required. [Complaint Exhibit 7, p 3.]

"R418.101 to R418.2324" are fee schedules for providers of services under the Worker's Disability Compensation Act, MCL 418.101 *et seq.*

The referendum appeared on the November 3, 1992 ballot as "Proposal D." Insurers, including some of the defendants in the present action, urged policyholders to vote for the proposition. (1992 policyholder letters, Complaint Exhibit 6.) Nonetheless, Proposal D was defeated by a margin of almost 100,000 votes.[6]

Soon after losing the referendum, the no-fault insurers again sought assistance from the Legislature. In the 1993 session, they persuaded it to enact 1993 PA 143 ("Act 143") (Appendix, pp 97a-99a).[7] Act 143 included many revisions of the no-fault statute, in particular MCL 500.3107(1). Act 143 also made extensive changes to MCL 500.3157. The effect of the act would have been to limit insurers' obligations to providers of medical services according to one of several possibilities. Subsection (2) would have allowed the insurer to decide whether to pay a provider under either the worker's compensation schedule (subsection (2)(a)) or a fee based on what it would be paid by a nonprofit health care corporation, such as Blue Cross/Blue Shield

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[5] Some items that were attached as exhibits to the circuit court complaint were not reproduced as exhibits in the Court of Appeals and have been omitted from plaintiffs' appendix. They are not essential to an understanding of the background of the present controversy.

[6] 2,480,032 to 1,482,577 (67.2% to 33.4%). 1993-1994 Michigan Manual, p 878.

[7] The bill passed in the house by 65 to 43. 1993 Journal of the House 478-479. The Senate vote was 20 to 1, with 16 not voting. 1993 Journal of the Senate 1890.

(subsection (2)(b)). (Appendix, p 97a-98a). Subsection (3) would have required the Insurance Commissioner to establish a provider fee schedule. (Appendix, p 98a.) The act also included a provision for a utilization review system that was essentially identical to that in SB 691. (Appendix, p 98a.)

Act 143 was strongly opposed by various constituencies. The legislative analysis reported:

> This bill has been described as a warmed-over Proposal D, the ballot proposal resoundingly defeated by the voters just months ago. . . .
>
> The combination of lower medical benefits, mandatory fee schedules for health care providers and facilities, higher deductibles, and limits on treatment could result in many victims of auto accidents getting inadequate or second-rate care and in many catastrophically injured victims not receiving the care they desperately need. Doctors, hospitals, ambulances, head injury networks, and others say the fee schedules proposed are inadequate. [House Legislative Analysis, p 10; Appendix, p 109a.]

A group of opponents of Act 143, including AOPP[8], initiated a petition drive to have the act placed on the 1994 general election ballot as a referendum issue. They obtained enough apparently valid signatures to satisfy the requirements of Const 1963, art 2, § 9[9]. The Commissioner of Insurance decided that the referendum would suspend the effective date of Act 143. Insurance Bureau Declaratory Ruling 93-159218-M (December 22, 1993).[10] His determination was affirmed by the Court of Appeals in an opinion issued March 31, 1994. *Farm Bureau Mutual Ins Co v Comm'r of Ins*, 204 Mich App 361; 514 NW2d 547 (1994). This Court denied the plaintiffs-insurers' application for leave to appeal. 445 Mich 917; 519 NW2d 892 (1994).

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[8] See *In re Farm Bureau Mutual Ins Co*, 445 Mich 917, 917; 519 NW2d 892 (1994).

[9] "[N]ot less than eight percent for initiative and five percent for referendum of the total vote cast for all candidates for governor at the last preceding general election at which a governor was elected."

[10] The full text of this bulletin (90 pages) is available from Westlaw, in the MIIN-BUL database.

The petition regarding Act 143 became "Proposal C" on the November 1994 general election ballot. It was defeated by a vote of 61% to 39% (646,794 votes). 1995-1996 Michigan Manual 955. The amendments to §3157, therefore, did not take effect. *Munson Medical Center v Auto Club Ins Ass'n,* 218 Mich App 375, 387 n 4; 554 NW2d 49 (1996) ("1993 PA 143 became Proposal C, which was rejected in the November 1994 general election"). West, Michigan Compiled Laws Annotated, § 500.3107 (2000 Supp), p 29.

The medical review system

In 1988-1992, several business organizations were incorporated in Michigan, to perform medical audits of insurance claims. They did business under such assumed names as "Review Works" (corporate identification number 462611, incorporated in 1989) (Complaint, Exhibit 11); "Rehab Works" (former corporate identification number 462611, also incorporated in 1989) (Complaint, Exhibit 12); "Linkage Enterprises, Inc." (corporate identification number 471696, incorporated in 1991) (Complaint, Exhibit 13); "Medcheck Medical Audit Services, Inc." (corporate identification number 457535, incorporated in 1992) (Complaint, Exhibit 14); "Medaudit Services, Inc." (also corporate identification number 457535, incorporated in 1992) (Complaint, Exhibit 15); "Recovery Unlimited, Inc." (corporate identification number 520214, incorporated in 1988) (Complaint, Exhibit 16); and "Medical Review Systems" (corporate identification number 520214, incorporated in 1988) (Complaint, Exhibit 17.)[11]

Linkage Enterprises, Inc., explained that it was organized in part:

> to provide auditing services on behalf of insurance companies and other entities entitled to auditing of medical and hospital bills. [Complaint, Exhibit 13.]

The largest of these companies is "Manageability Incorporated" (corporate identification number 540521, incorporated in 1989). Manageability has done business under several different

[11] Some corporations have more than one assumed name. None of the listed entities appears to do business outside of Michigan.

names, including "Auditpro" and "Indemnicare." It advertises its services to the business community:

> Like the prism that opens up a beam of light, Managed Care professionals must use the right tools to gain insight into what might otherwise be hidden. The right tools allow us to ask the most relevant questions, dig deeper, and find quality-driven, cost-saving answers. When it comes to medical cost containment, ManageAbility, Inc. has delivered unparalleled performance and service in Workers' Compensation and PIP Managed Care for over a decade. [www.managebility.com.]

Many Michigan no-fault insurers, including some if not all of the named defendants in the present action, availed themselves of the auditing companies' services and began reimbursing medical providers based on the auditing companies' recommendations. For example, in a letter dated April 3, 1992, a representative of defendant AAA wrote to one provider, stating

> We have contracted with a national firm to review bills for their reasonableness based upon the diagnostic codes, and locality. It is our position that the amounts approved are customary and reasonable for the services rendered. [Appendix, p 112a.]

A representative of Auto-Owners Insurance wrote to another provider on December 30, 1993:

> We have had an independent bill auditing company review your charges and they have adjusted payment for procedure code number 27750, treatment of closed tibia fracture. . . [Appendix, p 113a.]

See also Complaint Exhibit 52, Linkage Enterprises, Inc., review conducted for Secura Insurance Company. (Appendix, pp 115a-117a.)

The insurers' actions

Despite the decisive defeat of Proposal C in 1994, defendant insurance companies proceeded undeterred, almost as if the proposed amendments to MCL 500.3157(1) had actually taken effect. They continued to utilize and rely on review companies' recommendations about what to pay to health care providers.

The reviewers' recommended payments were often significantly less than the providers' charges. (Complaint Exhibits 21, 22, 23, 28, 32, 33, 34, 63-71.) In one case, for example, a provider explained to "Medcheck":

> [Y]our allowable for the split thickness skin graft of only $640.00 is considerably lower than what we have received from some other insurance companies. Total Group Services has paid us the entire $1,093.00 and Connecticut General has paid us $1,058.00. In comparison with other insurance companies I feel you should re-evaluate your payment scale. [Complaint, Exhibit 18.]

Another physician billed AAA a total $4,842.00, an amount which it demonstrated to be less than the state or national average charges for the services provided, yet AAA paid him only $3,369.00 (69.5%). (Complaint, Exhibit 33.)

When the director of a clinic at Michigan State University, which treats patients injured in auto accidents, attempted to examine the qualifications of some of the review companies' employees, it was denied access to the relevant information. (Appendix, pp 119a-121a). Auto-Owners wrote:

> You ask that substantial information for "all of their (Review Works') company principals and reviewers" be sent to you in support of Auto-Owners' use of Review Works to examine whether or not bills for medical treatment conform to our liability under Michigan No-Fault.
>
> We are not prepared to furnish that information, nor will we ask that Review Works assemble and furnish that information. . . . [Appendix, p 122a.]

That is, the review companies did not confine themselves to determining whether the providers' charges were "reasonable" for the services provided and no more than "customarily charged" to uninsured patients. MCL 500.3157. Rather, the insurance companies' auditors devoted themselves to determining whether providers' charges were within the range of "reasonable and customary" charges by other providers. Insurers approved of this change in the statutory language:

> It is true that the citizens of Michigan are paying insurance premiums for medical expenses incurred as a result of an auto accident, however, the No-Fault Act does not state we will pay 100% of services charges, rather *we owe for reasonable and customary charges*. [Complaint Exhibit 20, letter from AAA. Emphasis supplied.]

Review Works uses what it calls the "80th percentile" system. An employee described the company's method of determining "reasonableness" by saying[12], "where the 80th one bills is what it determines is the 80th percentile. . ." "The 80th percentile is where the 80th provider charged out of however many there are. . ." (Excerpt from deposition of Dianne Mateja[13], pp 63-64, 66-67; Appendix, pp 130a-131a.)

The "balance-billing" dilemma

When providers received less than they had billed for their services from insurance companies, some of them requested the remainder of charge directly from their patients, a procedure referred to as "balance-billing." Partly in response to this situation, then-Commissioner of Insurance David J. Deckhouse issued Insurance Bureau Bulletin 92-03. (123a-124a.) After quoting the applicable language from MCL 500.3107(1), the commissioner informed insurers that they were required to "provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance." (Appendix, p 124a.) In part, this would entail "warning" health care providers that "the insurer will defend the insured or claimant against any attempt to collect, and may also consider any other appropriate action to prevent its policyholder from being pursued for collection.") to "provide insureds and claimants with complete protection from economic loss for benefits

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[12] This Court's June 25, 2004 order directed defendants to "explain in detail the computations they use in determining whether a particular charge meets the '80th percentile test.'" (Appendix, p 73a.) As defendants are the appellees in this Court, plaintiffs' discussion here is based on limited the record before the courts to the present point.

[13] Some discovery, including this deposition, was carried out in the federal court case.

provided under personal protection insurance." In part, this would entail "warning" health care providers that "the insurer will defend the insured or claimant against any attempt to collect, and may also consider any other appropriate action to prevent its policyholder from being pursued for collection." (Appendix, p 124a.)

> The purpose of this bulletin is to remind no-fault insurers that they are required to provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance. . . .
>
> When such a dispute arises, an insurer will meet its statutory obligations by adhering to the following procedures. First, the insurance company must assume its statutory responsibility for complete protection of the insured. To do so, the insurer should notify the provider that the insurer is responsible for paying any reasonable charges, not the insured or claimant. . . . [H]ealth care providers should be warned that the insurer will defend the insured or claimant against any attempt to collect, and may also consider any other appropriate action to prevent its policyholder from being pursued for collection. [Insurance Bulletin 92-03, Appendix, p 124a. Emphasis supplied.]

Many no-fault insurers used the bulletin as a pretext for threatening health care providers who had requested payment from their patients.

> Under the Michigan Law, when a bill is in dispute, it is illegal for you to send them to collections. We ask that you cease with this action immediately.
>
> * * *
>
> Auto-Owners Insurance Company will defend its insured against any collection you may take. If you persist in pursuing this matter, we may need to take legal action against you. [Appendix, p 125a.]

AAA employed several form letters against providers, such as the following which was sent to many physicians in 1993:

> It has come to our attention that you have recently balance-billed our insured. Our insured is not responsible for these charges because he has medical coverage under his No-Fault insurance policy with the Auto Club Insurance Association (ACIA). Your charges were not paid in full because we based our payment to you in reliance on a medical review company's recommendations. You were previously given a copy of the audit report which is self-explanatory.
>
> Since you provided services to our insured for an automobile accident, you are subject to the Michigan No-Fault Statute. Pursuant to that statute, you may

charge a reasonable amount, but the charge cannot exceed the amount you usually accept in payment. The ACIA has paid what it considered to be a reasonalbe [*sic*] amount, based on the auditing report.

Our attorneys have advised us that if you continue to balance-bill our insured or report to a collection agency or credit reporting company that our insured has a delinquency, you may be violating the Michigan Collection Act and/or the Fair Credit Reporting Act and you may be subject to tort damages for libel or slander. [Appendix, p 126a. Emphasis supplied. See also Complaint Exhibits 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 81, 82, 83, 84, 85, 86, 88, 89, 90.]

Another letter that was sent to many providers said:

I am the claim representative with the Auto Club Insurance Association (ACIA) which insured [the insured] on the day of his automobile accident. Following the accident [he] received services from [you]. Since [the insured] was treated for automobile accident injuries, [he] falls under the control of the Michigan No Fault statute. [You are] allowed to charge a reasonable amount for reasonably necessary services but the charge cannot exceed what [you] customarily charge[].

In this case, the ACIA retained [a review company], a medical bill auditing company, which recommended that an amount less than the total charge be paid as being a reasonable and customary payment for the services rendered. The amount recommended by [the review company] was $[ ]. The ACIA disputes [your] entitlement to more than $[ ] from the ACIA or from [the insured].

If you continue to contact [the insured] regarding the alleged delinquency, you may be subject to tort damages for the intentional infliction of emotional distress. [Appendix, p 127a. Emphasis supplied. See also Exhibits 73, 74, 75, 76, 77, 78, 79, 80.]

Procedural History of the Present Case

On September 26, 1996, plaintiffs filed suit in the Eaton Circuit Court. AOPP was the lead plaintiff, but the caption included some 49 individual health care providers (48 medical doctors and a physical therapist) and two representatives of no-fault claimants. ACIA was the lead defendant; the remaining defendants were thirteen Michigan no-fault insurers[14] and five review companies. Plaintiffs were later permitted to amend the caption and add Auto-Owners Insurance Company as a defendant. (Circuit court docket entry #20; Appendix, p 3a.)

[14] One insurer, Lincoln Mutual, was dismissed by stipulation in 1997, after it was declared insolvent. (Circuit court docket entry #40; Appendix, p 4a.)

The complaint consisted of 15 counts. Count 1 requested that the court determine "the rights and legal relations" among the parties as to ten issues, summarized below:

1. May no-fault insureds select their own health-care providers without consulting their no-fault insurers?

2. May no-fault insurers condition payment on selection of specific health care providers?

3. May no-fault insurers control the selection of products, services or accommodations by their insureds?

4. May no-fault insurers control the compensation insureds contract to pay their health care providers?

5. Are no-fault insurers permitted to represent insureds in fee disputes without prior consultation with the insureds?

6. Are no-fault insurers authorized to threaten health care providers if they attempt to collect charges from no-fault insureds?

7. Are health care providers required to accept medical review companies' determinations of whether services or charges were reasonable?

8. May no-fault insurers and review companies employ group insurance rates, etc., in determining whether individual providers' fees are reasonable?

9. May no-fault insurers decide without consulting the insured what services were necessary and whether the charges were reasonable?

10. May no-fault insurers evaluate the necessity and reasonableness of services and charges without first consulting the health care provider? [Appendix, pp 127a-128a, excerpt from Complaint.]

Count 2 of the complaint requested interim injunctive relief. Count 3 alleged impairment of contractual rights and sought permanent injunctive relief. Court 4 alleged tortious interference with contractual relations and Count 5 alleged tortious interference with business relationships; Count 6 alleged conspiracy to interfere with contractual relations and business relationships. Count 7 was titled "Common Law Fraud." Counts 8-15 pled violations of the Racketeer Influenced and Corrupt Organizations Act, 18 USC 1961 *et seq.* ("RICO").

Proceedings in the federal courts

Defendants asserted federal jurisdiction based on the RICO counts and removed the case to the United States District Court for the Western District of Michigan. In an order dated June 23, 1997, Judge Robert Holmes Bell dismissed the RICO counts and remanded the rest of the case to the Eaton Circuit court. *AOPP v ACIA*, 176 F3d 315, 318 (CA6, 1999). Plaintiffs appealed to the United States Court of Appeals for the Sixth Circuit, which affirmed. 176 F3d 315. The gist of the holding was that defendants had not engaged in any activity that fit the statutory definition of "racketeering." 176 F3d 331. The court also held that plaintiffs could not state a claim for common law fraud. *Id.* Plaintiffs applied for certiorari to the United States Supreme Court, but their petition was denied. 528 US 821 (1999).

Proceedings in Eaton County

The case returned to Eaton County, where it was assigned to the Hon. Calvin E. Osterhaven.

On February 1, 1999, plaintiffs filed a motion pursuant to MCR 3.501 to certify the matter as a class action. The motion was adjourned for a period of time to permit discovery. (Tr II, p 5; Appendix, p 55a.) A hearing was held on January 14, 2000. (Tr II; Appendix, p 54a-63a.)

At the hearing, plaintiffs' counsel explained that plaintiffs were seeking class certification only as to the counts (1, 2 and 3) for declaratory and injunctive relief, all of which involved matters of law and not individual determinations of fact. (Tr II, pp 8, 15, 28; Appendix, pp 55a, 57a, 60a.)

The trial court denied the motion for class certification in an opinion and order dated March 31, 2000 (Appendix, pp 21a-24a). The court's decision was based on its determination that plaintiffs had failed to satisfy the "common question" requirement of MCR 3.501(A)(1)(b).

Subsequently, plaintiffs filed a motion for partial summary disposition, requesting a decision on their claims for injunctive and declaratory relief. (Circuit court docket entry # 165; Appendix, p 10a). Defendants responded with a cross motion for summary disposition of all the remaining counts of the complaint. (Circuit court docket entry # 172; Appendix, p 10a). The motions were heard together on November 29, 2000. (Tr III; Appendix, pp 54a-63a .)

The court issued an opinion and order, dated December 12, 2000, denying plaintiffs' motion and granting defendants'. (Appendix, pp 25a-36a.) For reasons that were never explained, the trial court's December 12 order did not reach plaintiffs' counsel until December 27, 2001. Plaintiffs filed a timely claim of appeal from that order on January 2, 2001.

In the meantime, also for reasons that are not apparent from the record, defendants' lead trial counsel submitted a proposed order of dismissal to the trial court. That order was signed on January 3, 2001. As a precaution, plaintiff filed a second claim of appeal, from the January 3, 2001 order, on January 24, 2001. That claim was dismissed by the Court of Appeals on February 22, 2001 for lack of jurisdiction.

The Court of Appeals issued its opinion on July 3, 2003, affirming the trial court's orders in all respects. *AOPP v ACIA*, 257 Mich App 365; 670 NW2d 569 (2003) (Appendix, pp 64a-71a.) Plaintiff's motion for reconsideration was denied on August 28, 2003. (Appendix, p 72a.)

Plaintiff filed an application for leave to appeal to this Court. Briefs *amicus curiae* in support of the application were submitted by the Michigan State Medical Society and the Michigan Health and Hospital Association. Defendants moved for leave to respond to the

amicus briefs, but in an order dated June 25, 2004, this Court simultaneously granted plaintiff's application for leave to appeal and denied defendants' motion as moot.

In addition, the order provided:

> The application for leave to appeal the July 3, 2003 judgment of the Court of Appeals is considered, and it is GRANTED. In addition to briefing the issues raised in the application for leave, we DIRECT defendants to explain in detail the computations they use in determining whether a particular charge meets the "80th percentile test." [Appendix, p 73a.]

ARGUMENT I

THE COURT OF APPEALS ERRED IN HOLDING THAT DEFENDANTS' ACTIONS ARE PERMITTED UNDER MCL 500.3157.

Standard of Review

Plaintiffs moved for a declaratory judgment "pursuant to MCR 2.605" "and/or partial summary disposition pursuant to MCR 2.116(C)(9) [failure to state a valid defense]." The trial court's opinion does not indicate which subrule or rules it considered or what standard it applied. (Opinion of 12/12/00, pp 2-6; Appendix, pp 26a-30a.) The standard of review, however, is de novo under either subrule.

> This Court reviews de novo the trial court's grant or denial of a motion for summary disposition. . . . When deciding a motion under MCR 2.116(C)(9), which tests the sufficiency of a defendant's pleadings, the trial court must accept as true all well-pleaded allegations and properly grants summary disposition where a defendant fails to plead a valid defense to a claim. . . Summary disposition under MCR 2.116(C)(9) is proper when the defendant's pleadings are so clearly untenable that as a matter of law no factual development could possibly deny the plaintiff's right to recovery. . . . Statutory interpretation is a question of law also reviewed de novo on appeal. . . . [*Abela v General Motors Corp*, 257 Mich App 513, 517-518; 669 NW2d 271 (2003), quoting *Slater v Ann Arbor Public. Schools Bd of Education*, 250 Mich App 419, 425-426, 648 NW2d 205 (2002). Citations omitted.]

This Court reviews a trial court's decision to grant or deny a motion for summary disposition de novo. *Mack v Detroit*, 467 Mich 186, 193; 649 NW2d 47 (2002). A motion for summary disposition brought under MCR 2.116(C)(8) "test[s] the legal sufficiency of the complaint on the basis of the pleadings alone." *Id.*

(a)

The Court of Appeals erred in holding that defendants' method of calculating their payments to providers constitutes "a proper reasonableness determination . . ."

i. No-fault insurers may not unilaterally determine how much they will pay health care providers for treating motor vehicle-related injuries.

As explained *supra*, the Michigan no-fault law directs that providers of medical care may charge a "reasonable amount" for their services to patients injured in motor vehicle accidents. MCL 500.3157. The statute also requires that no-fault insurers pay "reasonable" charges, including the cost of medical care. MCL 500.3107(1).

It is quite clear that no-fault insurers have not been permitted to decide, on their own, how much to pay a health care provider.

Before the Court of Appeals' opinion in the present case, the most recent decision on the subject was *Mercy Mt Clemens Corp v Auto Club Ins Assn*, 219 Mich App 46; 555 NW2d 871 (1996). Although it involved a discovery order, the underlying issue was almost the same as that presented here. The plaintiffs were health care providers who treated patients with no-fault insurance provided by the defendants. According to the Court of Appeals' opinion,

> Plaintiffs' hospitals provided medical care for patients injured in automobile accidents and routinely billed no-fault automobile insurers directly for the medical care provided to their insureds. Defendant was the no-fault insurer for a number of these patients. *Starting about spring of 1992, defendant and several other no-fault insurers stopped paying the full amounts billed for services provided by plaintiffs and, instead, began tendering lesser amounts. These lower payments were calculated using the rules for worker's compensation reimbursement of medical costs.* These amounts were significantly less than those billed by plaintiffs. [219 Mich App 48-49. Emphasis supplied.]

The plaintiffs sued the insurers, seeking full payment of the amounts billed. In response, the defendants argued that the plaintiffs could only "charge" "the amount customarily accepted by a plaintiff as payment in full." 219 Mich App 49. The defendants then sought to discover

what the plaintiffs accepted as "payment in full" from other sources, such as Medicare, Medicaid, Blue Cross, worker's compensation and HMO's or PPO's. The trial court granted the plaintiffs' request for a protective order. The Court of Appeals affirmed.

> Regardless of whether third-party health-coverage providers such as Medicare, Medicaid, worker's compensation, Blue Cross, HMOs, and PPOs are technically insurance carriers, *the amounts that plaintiffs accepted as payment in full from those entities cannot be used to prove the customary charge for those services under § 3157 of the no-fault act.* In prior cases this Court has treated such third-party health coverage as health insurance to be excluded from consideration when determining the customary charge under § 3157. [219 Mich App 55-56. Citations omitted. Emphasis supplied.]

Mercy Mt Clemens relied heavily on *Munson Medical Center v ACIA, supra*, which had been released just a few weeks earlier. The underlying facts in *Munson* were functionally identical to those of *Mercy Mt Clemens*. The hospital billed the defendant for treating no-fault insureds and "beginning in 1992, ACIA stopped paying the entire amount of Munson's no-fault fills and began paying only a *portion* of the charges," which it determined based on the workers' compensation fee schedule. 218 Mich App 378 (emphasis original). The defendant claimed that the hospital's charges were "unreasonable."

The court concluded forcefully:

> *ACIA's unilateral decision to reimburse Munson according to the worker's compensation scheme cannot be upheld given the controlling statutory language of the no-fault act.* In 1992, ACIA sought passage of a referendum, Proposal D, which would have permitted ACIA to pay no-fault claims according to fee schedules (and which required ACIA to reduce its premiums). Proposal D was soundly rejected. Again in 1994, ACIA attempted to obtain passage and approval of similar amendments, which would have expressly incorporated the worker's compensation fee schedules with an accompanying premium rollback. Again the effort was unsuccessful. *Despite its failure to obtain an amendment of the no-fault law, ACIA nonetheless unilaterally implemented the result it wanted. ACIA's use of criteria imposed by other statutory schemes or contractual agreements is*

hereby rejected as a matter of law. [218 Mich App 390. Footnote omitted. Emphasis supplied.][15]

Both the *Munson* and *Mercy Mt Clemens* panels looked to *Hofmann v ACIA*, 211 Mich App 55; 535 NW2d 529 (1995)) in reaching their conclusions. The plaintiffs in *Hofmann* were chiropractors who challenged the defendant's reimbursement for their services. One of the insurer's defenses was that the plaintiffs' charges violated MCL 500.3157. The defendant offered extensive proofs that the chiropractors billed no-fault insurers more for the same services than they billed patients who were paying their own bills.

The Court of Appeals agreed with the defendant that the chiropractors' practice was inconsistent with MCL 500.3157. "[W]hether there has been an impermissible § 3157 overcharge is determined by looking to the provider's customary charge 'in cases not involving insurance.'" 211 Mich App 104. The court, however, rejected the insurer's claim that it had been "overcharged" simply because the chiropractors accepted lower payments for x-ray services from Blue Cross-Blue Shield.

> ACIA's reasoning is premised on the principle that BCBSM's "payments" to plaintiffs for x-rays, as opposed to plaintiffs' "charges" to BCBSM for those x-rays, is the proper criteria to be used in determining the plaintiffs' "customary charge" for x-rays. This position is untenable, however, in light of the clear statutory language of § 3157, which states that a "charge" in a no-fault case "shall not exceed the amount [a] person or institution customarily charges for like products, services and accommodations in cases not involving insurance" (emphasis added). *Thus, ACIA's reliance on the amount that was "paid" by BCBSM, as opposed to the amount that plaintiffs "charged," is unwarranted.*

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[15] The same issue was raised, but not decided, in *McGill v Automobile Assn of Michigan*, 207 Mich App 402; 526 NW2d 12 (1994). There, the plaintiffs were injured parties who sued their no-fault carriers because the carriers had "wrongfully utilized the worker's compensation payment schedules to determine a reasonable payment" under MCL 500.3107(1). 207 Mich App 404-405. Because the defendants promised to protect the insureds against any collection actions from their health care providers, the Court of Appeals held that the plaintiffs had not suffered any injury. As a result, it "[did] not address the issue whether worker's compensation payment schedules are the proper standard for determining reasonable charges." 207 Mich App 409.

Furthermore, ACIA's position ignores the fact that *the amounts that plaintiffs receive in payment from BCBSM are subject to contractual limitations, whereas the amounts that ACIA must pay for covered medical expenses are not limited contractually.* [211 Mich App 113. Emphasis supplied.]

The court went on:

In essence, ACIA is asking this Court to establish a rule that, in situations where other health or accident insurance coverage does not exist, the obligation of a no-fault carrier must be limited to what a health insurer would have had to pay if health insurance existed, notwithstanding that the health insurer's obligation might be controlled by contract, whereas the no-fault carrier's is not. This position does not find support in the no-fault act.

* * *

[B]ecause ACIA acknowledges that it was charged approximately the same amount for x-rays that plaintiffs charged BCBSM, and because *ACIA did not present evidence of plaintiffs' customary charges for x-rays in other cases, we are constrained to conclude that ACIA failed to establish a § 3157 overcharge violation with respect to x-ray services.* [211 Mich App 114. Emphasis supplied.]

An insurer made a similar argument in *Johnson v Michigan Mutual Ins Co*, 180 Mich App 314; 446 NW2d 899 (1989). The original plaintiff was injured in a motor vehicle accident. He had no health or auto insurance and his claim was assigned to the defendant. The defendant argued that, because the plaintiff would have been eligible for Medicaid if he had not been in an auto accident, his health care providers were only entitled to what they would have received from Medicaid.

The Court of Appeals squarely rejected the insurer's argument.

[The insurer did not] question the reasonableness of the hospital's charges or the necessity of services provided, but instead sought to persuade the trial court that the hospital's charges could only approximate those reimbursable by Medicaid. *We find this an untenable position in light of the unambiguous statutory language of MCL § 500.3157; MSA § 24.13157, which clearly permits health care providers . . . to charge reasonable amounts not exceeding their customary charges for the products, services and accommodations* they provide to other injured persons in cases not involving insurance. [180 Mich App 321-322. Footnote omitted. Emphasis supplied.]

In the present case, the Court of Appeals cited *LaMothe v ACIA*, 214 Mich App 577; 543 NW2d 42 (1996). 257 Mich App 378, 380; Appendix, pp 68a, 70a. *LaMothe*, however, did not address the central issue in the present case. In *LaMothe*, the defendant employed an audit company and apparently relied on it to decide that some of the plaintiff's expenses were "unreasonable." The Court of Appeals held that a no-fault insurer was permitted to pay only the "reasonable" expenses for services provided, but it did not consider whether the method used by the audit company was acceptable under the no-fault statutes. Similarly, in *McGill v Automobile Assn of Michigan*, 207 Mich App 402; 526 NW2d 12 (1994), the court held that insurers were not liable for more than "reasonable" expenses, but did not address the determination of "reasonableness" under §3157.

It is clear from this line of case law that Michigan's courts have not permitted no-fault insurers to use alternate, external, standards to determine what constitutes a "reasonable" fee under MCL 500.3157.

ii. The "80th percentile" system that defendants use to determine what they will pay to providers is not "reasonable."

Plaintiffs did not argue that health care providers are not subject to *any* review by no-fault insurers. No court has held, however, the review companies' comparison method is the route by which this review may be accomplished.

The Court of Appeals in the present case dismissed the authorities cited above by asserting that defendants "[have not] utilized the amounts insurers have paid for a service, as was rejected for purposes of determining a 'customary' charge in *Munson* and *Hofmann*." 257 Mich App 381. This distinction between "charge" and "payment," however, is artificial, where the insurer will *pay* no more than what it determines should be "charged."

The Court of Appeals directed that "the trier of fact will ultimately determine whether a charge is reasonable." 257 Mich App 379. At the same time, however, the court explicitly approved of Review Works "80th percentile" method.[16] That method, however, has nothing to do with the objective "reasonableness" of the charge.

As it was described, the "80th percentile" system involves compiling a list of providers' charges and identifying "where the 80th one bills," "where the 80th provider charged out of however many there are. . ." (Appendix, pp 130a-131a.) This method automatically defines 20 percent of providers' charges as "unreasonable," no matter how much, or how little, they are. It is equivalent to saying that, in a group of people arranged by weight from lowest to highest, the 20 heaviest are "overweight," regardless of how much weight they actually carry. Far from controlling health care costs, such a system of comparisons gives providers an incentive to keep raising their charges.

Furthermore, defendants do not employ *only* the comparison-of-charges method described by Review Works' employee. Defendants clearly referenced other, irrelevant, payors:

> [T]he submitted charges are <u>far in excess</u> of that amount allowed by:
>
> - Blue Cross
> - Medicare
> - Michigan Workers Compensation Fee Schedule [Appendix, p 116a; Secura Insurance Company letter of July 7, 1993.]

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[16] In their motion to file a response to the amicus briefs, defendants stated that "the Court of Appeals did <u>not</u> rule that the 80th percentile method used by some insurers to review medical bills is a dispositive indicator of reasonableness." (Defendants' response, p 2; emphasis original.) The Court of Appeals, however, clearly *did* approve of this method. "[A]lthough defendants ACIA and Review Works use a formula, that formula is based on a survey of *charges* by other health-care providers for the same services, a sampling which we conclude is not prohibited by the statute for determining the reasonableness of charges for the same service." 257 Mich App 382.

In explaining its procedures, ManageAbility stated that it employed "several different data sources" and then "identif[ied] what [is] reasonable to our client." (ManageAbility letter of 12/30/92; Appendix, p 135a.)

> Among these are the HIAA (Health Insurance Association of America) tables, various health plan reimbursement schedules such as Blue Cross Blue Shield of Michigan, SelectCare, health Alliance Plan (HAP), and the Michigan Workers' Compensation Fee Schedule. Most importantly, we collect and analyze billing data from peer providers for like procedures throughout the state of Michigan. [Appendix, p 135a.]

Defendants, then, are relying for their determination of "reasonableness" on exactly the sources of comparision data that were rejected by the *Munson* line of authority.

iii. Defendants' reimbursement is not equivalent to a legislatively-adopted plan that incorporates safeguards for health care providers.

This Court stated recently that "[t]he Legislature is never required to obtain consent from those who are subject to its legislative power." *Taxpayers of Michigan Against Casinos v Michigan*, ___ Mich ___ (Docket No. 122830, rel'd 7/30/04), slip op pp. 9-10. But the Legislature is not a monolith. It "derives [its] . . . powers from the consent of the governed . . ." Declaration of Independence, para 2 (US 1776). A statute, therefore, although it may be *enforced* without consent, does not come into existence without the participation of the people by way of representation.

There are currently 14 jurisdictions with no-fault motor vehicle insurance laws, including Michigan. Several have systems, created by their legislatures, that limit payments to providers of medical care under the no-fault insurance system.[17] A review of these how these jurisdictions have balanced cost containment to benefit insurers with concerns of service providers is instructive. The point to be remembered here, however, is that these systems are all *legislative* enactments, not privately-developed plans adopted by insurers themselves.

[17] Research has not uncovered any comparable provisions in non-no-fault states.

No two systems are identical. Each includes some features employed by some of the defendants in the present case.

In New York, NY Ins Law 5108(a) provides that charges for treatment of motor vehicle injuries "shall not exceed the charges permissible under the schedules prepared and established by the chairman of the workers' compensation board for industrial accidents . . ." The statute, however, permits an exception "where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge." Doctors and hospitals, however, are accommodated under an elaborate fee-setting system that takes the providers' specialty and geographic region into account in setting the rate for a given service. 9 NY Comp Codes R & Regs, App II.

Hawaii also limits "charges and frequency of treatment for services" to those "permissible under the workers' compensation supplemental medical fee schedule." Hawaii Rev Stat Ann 431:10C-308.5(b). If there is no worker's compensation rate for a services, however, payment is set at "eighty per cent of the provider's usual and customary charges for these services." Hawaii Rev Stat Ann 431:10C-308.5(c). In addition, the statute also provides a dispute resolution procedure. Hawaii Rev Stat Ann 431:10C-308.5(e).

Pennsylvania ties no-fault medical payments to the Medicare reimbursement rate. 75 Pa Cons Stat Ann 1797(a). Payments are set at "110% of the prevailing charge at the 75th percentile; 110% of the applicable fee schedule, the recommended fee or the inflation index charge; or 110% of the diagnostic-related groups (DRG) payment . . . or the provider's usual and customary charge, whichever is less." Where no Medicare rate has been established, "the amount of the payment may not exceed 80% of the provider's usual and customary charge."[18]

[18] There are exceptions for treatment of at some trauma facilities and burn centers.

The system, however, provides for "peer review" and permits the provider to appeal for judicial relief. 75 Pa Cons Stat Ann 1797(b)(1), 75 Pa Cons Stat Ann 1797(b)(4).

Florida has a complex system for government of no-fault medical insurance benefits.[19] Insurers are only liable for a flat "[e]ighty percent of all reasonable expenses . . . ." Fla Stat Ann 627.736(1)(a). However, auto insurers may develop "preferred provider" networks, and if the insured uses a "preferred provider," "the insurer may pay medical benefits in excess of the benefits required by this section." Fla Stat Ann 627.736(10).

The same statute includes a number of provisions related to the "reasonableness" of the charges. Fla Stat Ann 627.736(5)(a) provides that "consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement . . ." The system permits an insurer to reduce payments, but requires that it "contact the health care provider and discuss the reasons" for its decision. Fla Stat Ann 627.736(5)(g).

NJ Stat 39:6A-4.6(a) provides that "fee schedules shall be promulgated on the basis of the type of service provided, and shall incorporate the reasonable and prevailing fees of 75% of the practitioners within the region," although specialists get the benefit of state-wide rates in some cases. The statute, however, also provides that "The commissioner may contract with a proprietary purveyor of fee schedules for the maintenance of the fee schedule, *which shall be adjusted biennially for inflation* and for the addition of new medical procedures" (emphasis supplied).

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[19] Florida's no-fault law has been repealed, but the repeal will not take effect until October 1, 2007.

In Utah, the insurance department is charged with determining the maximum recoverable fee. The statute sets up a detailed system for determining fees, based on rates in "the most populous county" in the state (Utah Code Ann 31A-22-307(2)(a)(i)), but then allows the insurance department to adopt "a schedule already established or a schedule prepared by persons outside the department, if it meets the requirements" of the statute. Utah Code Ann 31A-22-307(2)(c). Providers' recovery is then further limited to "the 75th percentile charge assigned to the service or accommodation under the relative value study." Utah Code Ann 31A-22-307(2)(b)(i).

Massachusetts requires a peer review procedure. "[N]o insurer shall refuse to pay a bill for medical services . . . if such refusal is based solely on a medical review of the bill or of the medical services underlying the bill, which review was requested or conducted by the insurer, unless the insurer has submitted, for medical review, such bill or claim to at least one practitioner" in the same field an specialty. Mass Gen Law Ann ch 90, 34M.

The remaining no-fault jurisdictions – the District of Columbia, Kansas, Kentucky, Michigan, Minnesota, North Dakota and Texas – do not have specific statutory limitations on what medical providers may be paid for treating motor vehicle accident injuries.

Defendants' review systems in Michigan are equally a hodge-podge of approaches. There are important elements missing, however: there are no built-in limitations and no statutory relief valves.

Compare the Michigan insurers' – private – system with the state systems reviewed. New York's underlying rate-setting system recognizes provider specializations and intrastate variation in business expenses. Hawaii has a nonjudicial provision for appeals. New Jersey makes adjustments for inflation. Utah's very restrictive set-up at least bases its percentile

reimbursement on what are likely the highest charges made within the state. Pennsylvania has an appeal system and Massachusetts requires that reviews be conducted by medical professionals in the same field. Florida softens its 80th percentile rule with provisions for preferred provider network.

The Michigan defendants use "Health Insurance Association of America tables;" "Blue Cross/Blue Shield rate tables," HMO rates, and the "Michigan workers' compensation fee schedule" plus "billing data from peer providers for like procedures throughout the state of Michigan" to decide how much they will pay. This system does not offer medical providers any way to assure that appropriate apples-to-apples comparisions being made. There is also no route of appeal, outside of small claims court or actions like this one.

It must be emphasized that the New York, New Jersey, Hawaii, and other statutes were all passed or amended as part of a democratic process. All interested parties – patients and providers as well as insurance companies – had at least the opportunity to offer input. This is emphatically not the situation when a medical audit company unilaterally imposes a plan on unwilling participants.

The Court of Appeals made a similar point in *Michigan Chiropractic Council, supra.* Farmers Insurance Company, one of the defendants in the present action, proposed a new type of no-fault policy, in which the insured would receive a reduction of the premium for personal protection insurance benefits in return for "agreeing to obtain medical treatment exclusively from providers in Farmers' PPO network." *Id.*, slip op p 2. The plaintiffs challenged the insurance commissioner's approval of the plan. The Ingham circuit court reversed the commissioner's decision and the Court of Appeals affirmed. The panel noted:

> Managed care, and in particular, the PPO option at issue, fundamentally alters the essential premise of Michigan no-fault insurance and is inconsistent with the no-

> fault act general benefit provisions. Incorporating managed care into the no-fault scheme, *however beneficial or desirable from a policy standpoint, cannot emanate from the innovations of insurance companies* or the courts, *but only from the Legislature itself.* [Slip op, p 11. Emphasis supplied.]

That is, no-fault insurers are only one group of players in the game. The Legislature made the rules and only the Legislature has the power to change them.

iv. Defendants' system requires the provider plaintiffs to accept the downside of a bargain they did not agree to.

It is black-letter law that a contract requires two parties and a "meeting of the minds." "[A] fundamental tenet of all contracts is the existence of mutual assent or a meeting of the minds on all essential terms of a contract." *Burkhardt v Bailey*, 260 Mich App 636, 655; 680 NW2d 453 (2004), citing *Quality Products & Concepts Co v Nagel Precision, Inc*, 469 Mich 362, 364; 666 NW2d 251 (2003).

Aside from hospitals, which are required to treat anyone who needs emergency care[20], medical providers can decide whether or not to render services and how they want to be paid for them. Of course, it is usually to their advantage to accept some compromise on their rates in return for the advantages of agreeing to work with a payment guarantor. The physician who is not a "participating provider" in the Blue Cross/Blue Shield system, for example, will be less attractive to the tens of thousands of Michigan residents whose health care expenses are paid or administered by the Blues. A practitioner who affiliates with an HMO is promised a larger stream of potential patients than one who hangs out his own shingle and the clinic that takes Medicare or Medicaid payments will have access to a large pool of beneficiaries.

That is, a provider can chose whether to participate in Blue Cross, an HMO, or even the Medicare or Medicaid program. Preumably, each provider makes an informed judgment that the

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[20] 42 USC 1395dd.

volume of patients or efficiencies of scale is sufficient to compensate for the contractual limitation on payment for its work.

Providers have no such contractual relationship with the multitude of no-fault insurers who provide personal protection benefits in Michigan. They must deal with all the disadvantages of individual billing and payments, yet under defendants' review system, they are treated as if they had agreed to accept a lower fee in return for avoiding exactly those drawbacks. It is as if a Wal-Mart customer insisted that she was required to offer only the wholesale price for a box of detergent, because that was all that the retailer had paid for the product in bulk.

v. The Court of Appeals' approach will needlessly increase the amount of litigation over no-fault provider payments.

"[T]he no-fault act was created in part to ease the burden on the court system and provide a manner in which *all* parties would have a fair opportunity to litigate legitimate no-fault claims." *Proudfoot v State Farm Mutual Ins Co*, 254 Mich App 702, 716; 658 NW2d 838 (2003), *rev'd in part on other grounds*, 469 Mich 476; 673 NW2d 739 (2003)[21] (emphasis supplied).

In the present case, the Court of Appeals held that "the trier of fact will ultimately determine whether a charge is reasonable." 257 Mich App 379. (Appendix, p 68a.) This decision will result in a multitude of claims by providers, such as plaintiffs, against no-fault insurers, such as defendants. Inevitably, the time and expense of such litigation will affect both the cost and quality of medical services available and the price of motor vehicle insurance. This outcome would be contrary to the purposes of the no-fault act

[21] This Court held that some of the expenses the plaintiff had been awarded by the trial court had not yet been "incurred" and reversed the part of the Court of Appeals' opinion holding the insurer was liable for interest and attorney's fees on them.

(b)

The providers' "customary" fees are not at issue.

The Court of Appeals' opinion makes multiple references to plaintiffs' "customary" fees. 257 Mich App 372, 375-382. (Appendix, pp 67a-69a.) "Reasonable" under §3157, however, does not mean the same thing as "reasonable and customary" in a health insurance policy. The statute limits providers only to what they "customarily charge[] . . . in cases not involving insurance." It does not require that they be paid only what a health insurance company has determined is the "reasonable and customary charge" for a given service. The latter is a term of art used in contracts; defendants cannot spontaneously substitute it for the clear language of the existing statute.

(c)

Defendants' actions in setting reimbursement to health care providers is a de facto unconstitutional exercise of legislative power, which was effectively delegated to them within the limitations of §3157.

i. The Court of Appeals should have considered this issue.

The Court of Appeals avoided consideration of plaintiff's argument regarding the delegation of legislative power by stating that "it "was not pleaded in the complaint, addressed by the trial court or raised in the statement of questions presented." (257 Mich App 381, n 5; Appendix p 69a.) The issue, however, does appear in plaintiff's complaint, at ¶124, and was presented in both plaintiffs' motion for protective order and their motion for partial summary disposition. (Tr I, pp 31-39, Appendix, pp 144a-146a; Tr III, pp 15-22, Appendix, pp 57a-59a.)

The trial court found other bases for granting defendants' motion and denying plaintiffs' and so did not address this argument. The Court of Appeals, however, "may review issues that were not decided by the trial court where the issue is one of law and all the necessary facts were presented." *Koster v June's Trucking, Inc*, 244 Mich App 162, 168; 625 NW2d 82 (2000).

Finally, MCR 7.212(5) requires that the appellant state in its brief "the questions involved in the appeal," not every subargument within the text.

ii. The Legislature may not delegate its powers without providing standards for those exercising the delegated authority.

It is well-established that "the Legislature may not delegate its lawmaking powers to private individuals or entities." *Neal v Oakwood Hosp Corp*, 226 Mich App 701, 721; 575 NW2d 68 (1998), citing *Osius v St Clair Shores*, 344 Mich 693, 698; 75 NW2d 25 (1956). See, e.g., *Attorney General v American Way Life Ins Co*, 186 Mich App 679, 685; 465 NW2d 56 (1991), holding that a circuit court, acting on a request for investigation from the Commissioner of Insurance, did not have authority to appoint a private accounting firm to audit two insurance companies that had refused to cooperate with the Commissioner.

Generally, "[t]he nondelegation doctrine forbids the delegation of legislative powers, not only to the executive or judicial branches, but also to non-Michigan governmental agencies or to private individuals or associations." *Taylor v Smithkline Beecham Corp*, 468 Mich 1, 8, n 5; 658 NW2d 127 (2003). In *Shavers v Attorney General*, 402 Mich 554; 267 NW2d 72 (1978), however, this Court concluded that the no-fault act had effectively turned private companies that write auto insurance into agents of the state, because purchasing auto insurance had been made mandatory.

> This legislation goes beyond a grant of a monopoly or an attempt to regulate a utility; there exists "a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the (regulated entity) may fairly be treated as that of the State itself". [402 Mich 597, citing *Jackson v Metropolitan Edison Co*, 419 US 345 (1974). Footnotes omitted.]

It follows, then, that no-fault insurers are subject to the same limits on delegation of Legislative power as other state agencies. "The Legislature must provide standards to an administrative agency for the exercise of power delegated to it." *Blank v Department of*

Corrections, 462 Mich 103, 124; 611 NW2d 530 (2000) (Opinion of Kelly, J., with Corrigan and Young, JJ., concurring). "To ensure satisfaction of due process requirements, a sufficient totality of safeguards, including 'standards,' must exist to assure that the public will be protected against potential abuse of discretion at the hands of administrative officials." *People v Lueth*, 253 Mich App 670, 677-678; 660 NW2d 322 (2002).

> [This] Court has enunciated a three-part test for determining whether a legislative delegation of power is valid: (1) the act must be read as a whole, (2) the act carries a presumption of constitutionality, and (3) *the standards must be as reasonably precise as the subject matter requires or permits*. . . The preciseness required of the standards will depend on the complexity of the subject matter at issue. . . . These guidelines are used to evaluate a statute "to ensure against excessive delegation and misuse of delegated power.". . . [*Kent County Aeronautics Board v Dept of State Police*, 239 Mich App 563, 587; 609 NW2d 593 (2000), *aff'd sub nom Byrne v Michigan*, 463 Mich 652; 624 NW2d 906 (2001). Citations omitted. Emphasis supplied.]

In *Blue Cross & Blue Shield of Michigan v Governor*, 422 Mich 1; 367 NW2d 1 (1985), Blue Cross/Blue Shield brought a declaratory judgment action, directed toward the constitutionality of 1980 PA 350, the nonprofit health corporations act. One challenge involved allegedly improper delegations of legislative authority. This Court agreed that one section of the act was unconstitutional, in part because it put no limits on the Insurance Commissioner.

> [T]he Insurance Commissioner must either "approve" or "disapprove" the factors proposed by the health care corporation, § 205(5). No guidelines are provided to direct the Insurance Commissioner's response.
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> * * *
>
> [T]he power delegated to the Insurance Commissioner is completely open-ended. The commissioner is starkly directed to "approve" or "disapprove" the proposed risk factors; the basis of the evaluation is not addressed. . . .
>
> * * *
>
> [S]ome criteria must be included to guide the Insurance Commissioner's preference of one risk factor over another. Without additional standards, the Insurance Commissioner has de facto veto power over the health care corporation's risk factors. This lack of clarity regarding the Insurance Commissioner's function permits the Insurance Commissioner to define the authority of the commissioner.
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> * * *

> [T]he lack of standards defining and directing the Insurance Commissioner's and the actuary panel's authority renders this dispute resolution mechanism constitutionally defective. [422 Mich 52-55.]

The court held that section of the act was an unconstitutional delegation of legislative power. 422 Mich 55.

In the present controversy, then, there are three possibilities:

1. The Legislature effectively delegated the power to regulate charges by providers of medical care to no-fault insurers, a group of private entities, which would be illegal.

2. The Legislature delegated the power to the de facto equivalent of a state agency, but allowed them unfettered discretion, which would also be illegal.

3. The Legislature delegated the power to regulate charges, within the guidelines of the statute, i.e., §3157.

The last choice is the only reasonable resolution of the matter. The Legislature would not have included the language of §3157 that "a provider may charge a reasonable fee" unless it meant that providers' fees were to be determined by the standard in that section. To look only at the "reasonableness" limitation of §3107(1) would permit the no-fault insurers, and their outside reviewers, to operate without the guidance required by the delegation-of-powers rule.

The trial court should have granted plaintiffs' motion based on this argument.

(d)

Because defendants' actions were unlawful, plaintiffs' conspiracy count should not have been dismissed.

"A civil conspiracy is a combination of two or more persons, by some concerted action, to accomplish a criminal or unlawful purpose, or to accomplish a lawful purpose by criminal or unlawful means." *The Mable Cleary Trust v The Edward Marlah Muzyl Trust*, ___ Mich App ___ (Docket No. 244744, rel'd 6/17/04), slip op, p 13.

The Court of Appeals here held only that, "plaintiffs simply failed to establish the underlying tort because they failed to establish any unlawful purpose or unlawful means in defendants' actions." 257 Mich App 384; Appendix, p 70a. As plaintiffs have demonstrated, however, defendants' actions were unlawful. Since it is undisputed that defendant insurers combined with defendant review companies to carry out their actions, there was a "combination of two or more persons" by "concerted action" to "accomplish" an "unlawful purpose." Therefore, plaintiffs stated a claim for civil conspiracy.

ARGUMENT II

PLAINTIFFS STATED A CLAIM FOR TORTIOUS INTERFERENCE WITH CONTRACTUAL AND BUSINESS RELATIONSHIPS.

Standard of Review

The trial court dismissed plaintiffs' tortious interference claims pursuant to MCR 2.116(C)(8). (Opinion and Order of 12/12/00; Appendix, pp 34a, 35a.) This Court reviews a trial court's decision to grant or deny a motion for summary disposition de novo. *Mack v Detroit*, 467 Mich 186, 193; 649 NW2d 47 (2002). A motion for summary disposition brought under MCR 2.116(C)(8) "test[s] the legal sufficiency of the complaint on the basis of the pleadings alone." *Id.*

(a)

Plaintiffs stated a claim for tortious interference with the contracts between plaintiff providers and their patients.

i. The trial court's analysis was flawed, because defendants' actions were per se wrongful.

In *Bahr v Miller Bros Creamery*, 365 Mich 415, 422; 112 NW2d 463 (1961), this Court stated, "the general rule [is] that the intentional and knowing inducement of a party to break his

contract with another party is a wrongful act, and actionable as such, unless reasonable justification or excuse can be shown." *Id.* at 422 (citations omitted).

"The elements of tortious interference are (1) a contract, (2) a breach, and (3) an unjustified instigation of the breach by the defendant." *Mahrle v Danke,* 216 Mich App 343, 350; 549 NW2d 56 (1996).

> "[O]ne who alleges tortious interference with a contractual or business relationship must allege the intentional doing of a per se wrongful act or the doing of a lawful act with malice and unjustified in law for the purpose of invading the contractual rights or business relationship of another." [*Jim-Bob, Inc v Mehling,* 178 Mich App 71, 95-96; 443 NW2d 451 (1989).]

A defendant's actions are "unlawful" if "done to accomplish an unlawful purpose, i.e., to bring about a breach of contract." *Bahr, supra,* 365 Mich 423.

A defendant is not immunized from liability for interference with a contract simply by pleading that it had a business purpose:

> *[T]he fact that certain actions are taken with the intent that they inure to the personal or pecuniary benefit of the defendant cannot, per se, in our view, weave a broad and impenetrable blanket of immunity from liability for those actions.* Certainly, in nearly all cases of interference, the defendant hopes to benefit by way of a resulting advancement of its personal or business interests. But these ends do not necessarily justify the means undertaken. *A defendant may not, with impunity, sabotage the contractual agreements of others, and that defendant's cry that its actions were motivated by purely business interests cannot, standing alone, operate as a miracle cure making all that was wrong, right.* [*Jim-Bob, Inc, supra,* 178 Mich App 96-97. Footnotes omitted. Emphasis supplied.]

The Court of Appeals called "sending letters knowing them to contain false allegations" "clearly . . . unethical conduct" in *Trepel v Pontiac Osteopathic Hosp,* 135 Mich App 361, 377; 354 NW2d 341 (1984).

In *Woody v Tamer,* 158 Mich App 764; 405 NW2d 213 (1987), the Court of Appeals quoted extensively from the Restatement of Torts in a case where the plaintiffs alleged that the

defendants had deliberately defaulted on a land contract, in order to induce the plaintiffs to default on a mortgage:

> "d. Induces or otherwise purposely causes. The word 'induces' refers to the situations in which A causes B to choose one course of conduct rather than another. Whether A causes the choice by persuasion or by intimidation, B is free to choose the other course if he is willing to suffer the consequences. Thus inducement operates on the mind of the person induced. The phrase 'otherwise purposely causes' refers to the situations in which A leaves B no choice . . . The rule stated in this Section applies to any purposeful causation whether by inducement or otherwise. *The essential thing is the purpose to cause the result.* If the actor does not have this purpose, his conduct does not subject him to liability under this rule even if it has the unintended effect of deterring the third person from dealing with the other. It is not necessary, however, that the purpose to cause the breach of contract or failure to deal be the actor's sole or paramount purpose. *It is sufficient that he designs this result whether because he desires it as an end in itself or because he regards it as a necessary, even if regrettable, means to some other end....*" [4 Restatement Torts [2d], § 766, Comment d, pp 54-55, quoted at 158 Mich App 774-775. Emphasis supplied.]

The *Woody* court went on,

> Although what constitutes "improper" conduct of a quality which would be without justification is not clearly defined . . . it is readily apparent that several of the Restatement 2d factors addressing "improper" conduct are applicable to these pleadings. *We are therefore inclined to allow a full development of the plaintiffs' case, rather than make a determination on the pleadings alone.* [158 Mich App 775-776. Emphasis supplied.]

In an older case, the plaintiff alleged that the defendant had forced the customers on his milk route to deal with it instead of him. This Court held:

> Defendants' refusal to accept further deliveries of milk by plaintiff was wrongful in the light of the evidence in the instant case because it was done to accomplish an unlawful purpose, i.e., to bring about a breach of contract. It therefore follows that the problem of proximate cause disappears from consideration in the case. *Defendants cannot be heard to say that they should not be held liable for the injury caused plaintiff by their unlawful acts merely because they could have caused the same injury by a lawful act.* [*Wilkinson v Powe*, 300 Mich 275, 285; 1 NW2d 539 (1942). Emphasis supplied.]

In the present case, there is no dispute that contracts existed between the provider plaintiffs and their patients, defendants' insureds. The providers rendered services to the

insureds and expected payment in return. There is also no doubt that these contracts were breached; the providers did not receive full payment from their patients. The breaches were instigated by defendants, who informed the patients that they were not liable for payment for the services rendered. The breaches were brought about via letters containing false allegations; *Trepel, supra.*

In its opinion granting defendants' motion, the trial court stated:

> *Plaintiffs have failed to establish any illegal, unethical, or fraudulent reason that was motivating the Defendants* to tell their insureds they were not responsible for payment of their medical bills. *The Plaintiffs have failed to prove that the Defendants were motivated* by anything except their obligation to defend and indemnify their insureds. In fact, the insureds are directed to do so by a recent Interpretive Statement issued by the Commissioner of Insurance. . . .
>
> * * *
>
> The Defendants in this case were simply relieving the patients from liability due to their promise to defend and indemnify the patients. *There is no evidence that this action was illegal, unethical, or fraudulent.* Therefore, summary disposition is appropriate. [Opinion of 12/12/00, p 9; Appendix, p 33a. Emphasis supplied.]

Defendants' motivation was not dispositive. An act may be a tortious interference if it is "the doing of a lawful act with malice" **or** "the intentional doing of a per se wrongful act." *Jim-Bob, Inc, supra*, 178 Mich App 95-96. As was said in *Bahr, supra*, an action is "unlawful" if "done to accomplish an unlawful purpose, *i.e., to bring about a breach of contract.*" 365 Mich 423 (emphasis supplied). If defendants deliberately intervened in the contractual relationship between plaintiffs and their patients, they are liable for tortious interference with contractual relationships.

The Court of Appeals held:

> In this case, plaintiffs failed to establish that defendants intentionally committed an act wrongful per se or an unjustified lawful act with the purpose of interfering with plaintiffs' business and contractual relationships. As previously discussed, defendants lawfully reviewed plaintiff providers' medical charges for reasonableness and agreed to defend and indemnify their insureds for any responsibility in the payment of the remaining balance. Further, the trial court

> correctly pointed out that plaintiffs failed to show that defendants were motivated by anything other than their right under§ 3107 to limit their liability to charges that are reasonable and reasonably necessary. Moreover, defendants did not commit an act wrongful per se or an unjustified lawful act by advising their insureds that the health-care provider would not be fully reimbursed and that the insurer would indemnify and defend the insureds if the health-care provider sought additional monies from them. [257 Mich App 383-384.]

The panel's analysis misses the point. Even if defendants' actions of "advising their insureds that the health-care provider would not be fully reimbursed" were not "per se wrongful," they could be tortious for if done for an "unlawful purpose."

In short, defendants' attempts to interfere with plaintiffs' patient contracts were unjustified, because they were in violation of MCL 500.3107(1); see Argument I, *supra*. Defendants' allegedly lawful basis for their actions cannot justify summary disposition in itself.

ii. Defendants' communications with providers were unethical or illegal.

The trial court overlooked the fact that at least some of the insurers' letters were frankly fraudulent. They included such statements as:

> Under the Michigan Law, when a bill is in dispute, it is illegal for you to send them to collections. . . If you persist in pursuing this matter, we may need to take legal action against you. [Appendix, p 125a.]

> Our attorneys have advised us that if you continue to balance-bill our insured or report to a collection agency or credit reporting company that our insured has a delinquency, you may be violating the Michigan Collection Act and/or the Fair Credit Reporting Act and you may be subject to tort damages for libel or slander. [Appendix, p 126a.]

> If you continue to contact [the insured] regarding the alleged delinquency, you may be subject to tort damages for the intentional infliction of emotional distress. [Appendix, p 127a.]

> Pursuant to that statute, you may charge a reasonable amount, but the charge cannot exceed the amount you usually accept in payment. [Appendix, p 126a.]

> [You are] allowed to charge a reasonable amount for reasonably necessary services but the charge cannot exceed what [you] customarily charge[]. [Appendix, p 127a.]

These statements are, at the best, misleading and at worst, outright falsehoods.

1. Sending a bill to a patient is not "illegal." The no-fault statute requires that no-fault insurers pay for medical care, etc.; it contains no restrictions on how health care providers collect their bills. Furthermore, no insurance company would have a basis for "taking legal action against" a provider for billing its patients. Under the Insurance Bulletin that defendants rely on, insurers are required to defend their insureds in collection actions, but that does not give them any rights *against* the provider.

2. There is no "Michigan Collection Act." The reference appears to be to the Collection Practices Act, MCL 445.211 *et seq.*, which was repealed in 1980. It was replaced by a series of occupational regulations, found at MCL 339.901 *et seq.* That act, however, applies only to third-party debt collectors, not persons personally attempting to collect debts owed to them. See MCL 339.901(b)(i). The federal Fair Debt Collection Practices Act contains an analogous provision. 15 USC 1692a(6). The federal statutes on consumer reporting are, at most, marginally applicable; see 15 USC 1681s-2 (reporting of "disputed") debts.

3. There is no way any of the plaintiffs could have been liable for "libel or slander" as a result of their collection actions. "A communication is defamatory if, under all the circumstances, it tends to so harm the reputation of an individual that it lowers the individual's reputation in the community or deters others from associating or dealing with the individual." *Kefgen v Davidson*, 241 Mich App 611, 617; 617 NW2d 351 (2000). In the modern age, the fact that a person owes money to a physician because of an insurance dispute would not "harm the reputation" of an individual so as to "deter others from associating" with him. Finally, defamation also requires "an unprivileged publication *to a third party*." *Mino v Clio School*

District, 255 Mich App 60, 72; 661 NW2d 586 (2003) (emphasis supplied). The providers' billings were sent directly to their patients, not "published" to anyone else.

4. "In order to invoke the tort of intentional infliction of emotional distress . . . plaintiffs had to establish (1) extreme and outrageous conduct, (2) intent or recklessness, (3) causation, and (4) severe emotional distress." *Graham v Ford*, 237 Mich App 670, 674; 604 NW2d 713 (1999). "The test is whether "the recitation of the facts to an average member of the community would arouse his resentment against the actor, and lead him to exclaim, 'Outrageous!'" *Id.* at 674-675. "Balance-billing" a patient for the amount of his bill not covered by insurance is not "outrageous" conduct. Indeed, it is something that anyone should anticipate because, outside of the special contexts of no-fault insurance and worker's compensation, a patient is *always* responsible for the total amount of the bill, whether or not he has insurance.

5. A provider is not prohibited from charging a no-fault insured more than "the amount you usually accept in payment" or "what [you] customarily charge[] . . ." What a provider "usually accept[s] in payment" is, as has been discussed *supra*, often considerably different from its charge "in cases not involving insurance . . ." The statute prohibits the provider from recovering more than the latter, not the former.

Defendants' communications to plaintiffs and others like them, then, were out of the bounds of actions permissible to protect defendants' insureds.

(b)

Plaintiffs stated a claim for tortious interference with business relationships.

> The elements of tortious interference with a business relationship are the existence of a valid business relationship or expectancy, knowledge of the relationship or expectancy on the part of the defendant, an intentional interference by the defendant inducing or causing a breach or termination of the relationship or expectancy, and resultant damage to the plaintiff. [*BPS Clinical Laboratories v Blue Cross & Blue Shield of Michigan (On Remand)*, 217 Mich App 687, 698-699; 552 NW2d 919 (1996).]

Tortious interference with business relations may be caused by defamatory statements. *Wilkerson v Carlo*, 101 Mich App 629, 632; 300 NW2d 658 (1980).

In *Winiemko v Valenti*, 203 Mich App 411; 513 NW2d 181 (1994), the Court of Appeals stated that:

> [T]his Court [has] consistently applied the elements of tortious interference . . . in accordance with 4 Restatement Torts, 2d, §§ 766B, 767. . . . Under the Restatement 2d, *liability may be imposed for improper conduct that prevents either party from continuing a business relationship*:
>
> > One who intentionally and improperly interferes with another's prospective contractual relation (except a contract to marry) is subject to liability to the other for the pecuniary harm resulting from loss of the benefits of the relation, whether the interference consists of
> >
> > (a) inducing or otherwise causing a third person not to enter into or continue the prospective relation, or
> >
> > (b) preventing the other from acquiring or continuing the prospective relation. (4 Restatement Torts, 2d, § 766B, p. 20.)
>
> [203 Mich App 416-417. Emphasis supplied.]

The torts of tortious interference with an advantageous business relationship and interference with an existing contract are "distinct." *Bonelli v Volkswagen of America*, 166 Mich App 483, 496 n 4; 421 NW2d 213 (1988).

> *[P]er se illegal acts by an interferor are not a prerequisite to liability under the tort of interference with contractual or business relations.* . . . [O]ne who alleges tortious interference with a contractual or business relationship must allege the intentional doing of a per se wrongful act or the intentional doing of a lawful act with malice and unjustified in law for the purpose of invading plaintiff's contractual rights or business relationship. [*Feldman v Green*, 138 Mich App 360, 368-369; 360 NW2d 881 (1984).]

A worker's compensation case, *Dolenga v Aetna Casualty & Surety Co*, 185 Mich App 620; 463 NW2d 179 (1990), is of interest. The plaintiff operated a company that provided rehabilitation services, including vocational rehabilitation, to injured parties. A physician

referred a client to him; Aetna was the client's worker's compensation insurer. Aetna disagreed with the physician's choice of vocational rehab service provider and told the doctor not to refer any more patients to the plaintiff.

> Defendant Joanne Shankin, a registered nurse in the employment of Aetna as a rehabilitation coordinator . . . sent a letter to Dr. Baghdoian . . . directing [him] to cease making any referrals to any specific rehabilitation vendors, and in particular to plaintiffs. Shankin's letter further claimed to reserve its "right" under the Workers' Disability Compensation Act to make its own referrals. [185 Mich App 622.]

The plaintiff sued Aetna for tortious interference with a business relationship. The Court of Appeals held that the injured worker had the right to chose his service provider. *Id.* at 624-626. As to the tortious interference claim, the court held that summary disposition was inappropriate.

Although the defendant's position was that "[an]other vendor was better suited to provide" the client's services, the court stated that "Plaintiffs' theory of this case presents a much darker picture." 185 Mich App 626.

> Specifically, plaintiffs suggest that defendants' motivation for steering Bobier away from plaintiffs and to another vendor arises not from their concern with Bobier, but with their dislike of plaintiffs and, more importantly, their inability to control plaintiffs. [P]laintiffs are in a position to present evidence that defendants choose a rehabilitation services provider on the basis of the provider's willingness to follow defendants' dictates. . . Plaintiffs also have evidence to suggest that their reputation in the industry is one of being a "client advocate" and pressing the needs of their clients when the carriers attempt to terminate services prematurely, or at least prematurely in plaintiffs' judgment.
>
> *If the facts are as plaintiffs paint them, defendants' motivation was certainly improper*, namely, attempting to control the referral process in order to be able to control the services provided claimants and to be able to terminate those services without regard to the claimant's right to continue to receive those services. Further, under plaintiffs' version of the facts, defendants attempted to maintain their control by silencing the voices of client advocates, such as plaintiffs, by precluding the flow of business to vendors with such a reputation. . . . [185 Mich App 626-627.]

The panel also pointed to the letter that the defendant had sent to the referring physician as evidence of "interference with plaintiffs' business relationships." 185 Mich App 627. "

> *[The nurse's letter] falsely states that defendants have the right under the compensation act to select the vendor* and that Dr. Baghdoian has no authority to make referrals. As discussed above, *this is simply not true.* . . . [185 Mich App 628.]

The court concluded that summary disposition was not appropriate:

> [T]he question whether defendants were acting with an improper motive remains in dispute. . . . [T]here is certainly evidence from which the jury could conclude that defendants were acting improperly, unethically, fraudulently, and possibly even illegally. The important point, however, is that *this is a question for the jury to answer and the trial court erred in granting summary disposition.* [185 Mich App 626-628. Footnote omitted. Emphasis supplied.]

In the present case, the Court of Appeals dismissed *Dolenga* by saying that "no evidence exists that defendants suggested to any of the insured to switch health care providers." 257 Mich App 384. In *Dolenga*, however, the court's decision was not based on allegations that the insurer had induced the insured to seek another physical therapist. Rather, the court noted that "If the facts are as plaintiffs paint them, defendants' motivation was certainly improper, namely, *attempting to control the referral process. . .*" 185 Mich App 627 (emphasis supplied).

In the case at hand, there existed an advantageous business relationship between plaintiff providers and their patients. Defendants were indisputably aware of these relationships. Defendants intentionally interfered with the relationship or expectancy by falsely telling patients that they were not liable to plaintiffs for the services provided. Plaintiffs suffered damages. Thus, plaintiffs stated a claim for tortious interference with advantageous business relationships.

RELIEF REQUESTED

Plaintiffs request that this Court reverse the July 3, 2004 opinion of the Court of Appeals.

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